California Response to the *Basic Health Program, Request for Information*
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A. General Provisions

1. What are some of the major factors that States are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the State and/or consumer that would make this option more or less attractive to States? If so, what are they?

Potential Benefits:

- Can the Basic Health Program (BHP) provide lower premiums and cost sharing and/or a richer set of benefits compared to coverage offered by the Exchange offerings for this population?
- Does the BHP option improve the finances of safety net providers, increasing their role in serving the BHP-eligible population, or at least maintaining the current revenue stream that they receive for serving this population?
- If the BHP relies on managed care plans that participate in Medi-Cal, may it improve the continuity of coverage and care when enrollees' income changes if plans and providers participate in Medi-Cal, Health Families, the BHP and as QHPs in the Exchange?
- Would it allow for greater purchasing power and administrative economies of scale by adding covered lives to MRMIB?
- May it allow for parents of Healthy Families children to enroll in the same plans as their children?

Potential Challenges:

- Until federal BHP guidance is released, a comprehensive financial and administrative feasibility analysis cannot be completed.
- Can the state use any portion of the 95% of tax credits and cost-sharing subsidies to cover the BHP's administrative costs?
- What financial risk is there for the state to balance revenues and expenditures for BHP?
- Will the BHP reduce the viability and purchasing leverage of the California Health Benefit Exchange (HBEX)? For example:
    - Will the BHP divert a significant group of high-subsidy and potentially low-risk participants?
    - Will the smaller Exchange enrollment reduce the purchasing leverage of the Exchange in negotiating with health plans?
    - Will the smaller Exchange enrollment affect the size of assessments needed to support Exchange operating costs?
- Does the BHP add to the complexity of eligibility processes because people need to be assessed for eligibility for an additional program and more frequently?

- Could the BHP significantly disrupt continuity of care for populations due to churn at the 200% FPL threshold and if there is a mismatch of provider networks between BHP, Exchange and employer-sponsored coverage plans?
- Could the BHP significantly disrupt continuity of care for populations due to a significant mismatch between SCHIP and Medi-Cal provider networks? If the BHP relies on plans now serving the Medi-Cal program, can these plans and their providers handle the increased demand for services?
- Will consumers be satisfied with the BHP plans if they offer narrower provider networks than those available to enrollees through plans participating in the Exchange?
- To the extent the BHP achieves lower cost sharing, or higher benefits, through lower payments to providers, what are the potential impacts on public purchasers, private purchasers, and the Exchange?

The attractiveness of the Basic Health Program depends critically on the details of the regulations governing its operation. The following issues will be important to states:

- Flexibility to use federal funds that would have constituted tax subsidies and cost-sharing reductions to support BHP administration.
- Limits to financial risk to the states if the costs of BHP enrollee coverage exceed federal funding.
- Managing BHP costs through eligibility rules that offer enrollment stability when enrollee incomes fluctuate.

2. What are key considerations for States in placing responsibility for a Basic Health Program within the State organizational structure?

The decision regarding the location for the administrative responsibility of the BHP is tied to the fundamental reasons for creating the BHP. If the purpose is to provide a more affordable option to potential enrollees in the Exchange, then it makes sense to give the administrative responsibility to the Exchange to allow for close coordination of the BHP with the Exchange. If the BHP is intended to provide more continuity of care for Medi-Cal recipients as their incomes increase, administration by the Medi-Cal agency could make sense. Better coordination between parent coverage through the BHP and child coverage through CHIP might argue for administration by the CHIP agency.

It is unclear if the state agency designated to administer a BHP could effectively assume responsibility for up to 800,000 new lives without considerable “ramp up” time. Another key consideration about where to locate the BHP is to align strategies (with the Exchange, for example) to maximize purchasing power and drive quality and innovation.

3. What are the challenges and costs associated with managing a Basic Health Program?

Many of the challenges in managing the Basic Health Program are similar to the challenges that will be faced by the Exchange and Medi-Cal in managing the expansions in coverage and the resulting demands for more services. These pressures are likely to increase the costs of

coverage. The important challenge for the BHP is whether funding under the program will be sufficient to cover the costs of the program and still offer more affordable coverage to its enrollees.

4. **Are States that are exploring the Basic Health Program considering implementation for 2014, or for later years? What are the key tasks that need to be accomplished, and within what timeframes, to implement the Basic Health Program in a timely fashion? What kinds of business functions will need to be operational before implementation, and how soon will they need to be operational? Are there opportunities to leverage existing systems and increase efficiency within the State structure? To what extent have States begun developing business plans or budgets relating to Basic Health Program implementation?**

5. **To what extent have States already begun to assess whether to establish a Basic Health Program? What internal and/or external entities are involved, or will likely be involved in this planning process?**

California has reviewed various policy papers and quantitative analyses regarding the Basic Health Program from Mercer, the Urban Institute, Manatt, Milliman, and others. The California HealthCare Foundation commissioned a financial feasibility analysis of a BHP from Mercer. The Institute of Health Policy Solutions wrote a paper proposing a solution to the affordability and continuity of care questions keeping this population in the Exchange as an alternative to the BHP. Further quantitative and policy analyses are expected in California. Copies of all of these materials are available upon request.

6. **What guidance or information would be helpful to States, plans, and other stakeholders as they begin the planning process? What other terms or provisions need additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?**

Can federal payments for the BHP be used for administration of the program? Our current understanding is that a state that has a BHP is entitled to receive 95 percent of the value of the premium tax credit and cost-sharing reductions that the federal government otherwise would pay for Exchange coverage for each individual enrolled in the BHP. The funds are to be deposited in a trust and used only to pay premiums, reduce cost-sharing, or provide additional benefits to individuals in standard health plans. They may not be used as matching funds (ACA § 1331(d)).

Can the state Health Benefits Exchange administer the BHP?

How would risk pooling work between the BHP and the Exchange (i.e. if the BHP population must be a separate risk pool)? The federal government should also consider additional risk pooling possibilities, such as allowing all carriers in one risk adjustment pool and assigning clinical risk to each individual and share cost by risk adjustment.

Might BHP regulation address continuity of care by potentially requiring QHPs to participate in Medicaid, CHIP and BHP?

7. How can the Administration provide technical assistance? What form(s) of technical assistance would be most helpful to States?

Technical assistance around furthering the cost assumptions of implementing a BHP would be beneficial in evaluating the financial viability of a BHP for California. In particular, it would be helpful to have assistance in determining the impact on the risk pool, purchasing and contracting power, and administrative efficiency of the HBEx, depending on whether or not there was a BHP or if the BHP were operated within or separate from the Exchange.

Additionally, states could use assistance about how to include BHP eligibility rules in the federal enrollment system should states using the federal exchange offer a BHP.

B. Standard Health Plan Standards and Standard Health Plan Offerors

1. What additional standards, if any, should standard health plans participating in a State's Basic Health Program meet? What consumer protections should be included? How should quality and performance be measured?

2. What plan design issues should be considered? How likely is it for a State to consider an expanded benefit package beyond the essential health benefits for standard health plans participating in a State's Basic Health Program? What are the advantages and disadvantages of an expanded benefit package for standard health plans compared to qualified health plans?

3. What is the expected impact of standard health plans on provider payments and consumer access?

C. *Contracting Process*

1. What innovative features should States consider when negotiating through the contracting process with standard health plans to participate in a Basic Health Program?

The state could require QHPs participating in the Exchange to also participate in the BHP, as well as Medi-Cal and Healthy Families.

2. What considerations exist in determining whether to utilize the regional compact authority in Section 1331(c)(3)(B) of the Affordable Care Act? Are States interested in pursuing this approach?

D. Coordination With Other State Programs

1. What is the expected impact of a Basic Health Program on the Exchange's purchasing power and viability? How might States organize a Basic Health Program with respect to purchasing structure?

Mercer's study projected that 4.56 million Californians likely would be eligible for the Exchange and some 2.58 million likely would enroll. Mercer also estimated that 723,000 Californians likely would enroll in the BHP, leaving an estimated California Exchange population of approximately 1.86 million. According to this projection, the BHP would enroll approximately 28% of the Exchange-eligible population. Another study by The Institute for Health Policy Solutions reports an estimate by the Urban Institute that California's tax-credit-eligible Exchange population would be reduced by more than half if a BHP were established in California.

The reduction in enrollment in Exchange plans could reduce the purchasing power of the Exchange and could affect its ability to attract high-value plans and/or negotiate the best possible terms. On the other hand, the size of California's Exchange population will be larger than most other state Exchanges. In addition, it may be possible to mitigate the loss of any purchasing power by aligning the purchasing strategies of the BHP, Medi-Cal, and the Exchange to maximize public purchasing leverage.

2. What is the expected impact of a Basic Health Program on plans participating in the Exchange in terms of risk profile, enrollment, and premium stability? What is the expected impact on overall coverage?

Establishing a BHP would impact the Exchange as it would reduce the number of individuals seeking coverage through the Exchange and participating in the risk pool. Depending on the health characteristics of who is in the BHP, this could positively or negatively affect Exchange premiums. The potential negative impacts on the risk mix of the Exchange could, however, be mitigated to the extent states are allowed by federal guidance to use their regulatory authority to require a state-licensed insurer to comply with the same rules that govern the individual market, including pooling its BHP members with its members in the individual market. Regardless of whether a BHP plan is sponsored by a state-licensed insurer, the State may, depending on federal guidance, be able to include the plan in its risk-adjustment and reinsurance systems.

The level of premiums and cost-sharing in BHP and in the Exchange will impact on the risk of the population that enrolls in either. On the one hand, higher premium and cost-sharing typically leads to adverse selection (and a higher risk profile) whereby sicker individuals who need services enroll at a higher rate. Lower premiums and cost-sharing levels, as proposed for the BHP, could result in a better risk profile in the Exchange because lower income people with potentially more health issues would not be in the Exchange risk pool. On the other hand, there is no evidence about enrollment and "take up" of insurance under an individual mandate in the United States so it is rather speculative at this point to project about adverse selection.

3. **What are some of the major factors that States are likely to consider in determining how to structure their Basic Health Program? Are States likely to structure the Basic Health Program as one component of its other public programs? Are States likely to consider a CHIP-like approach or other options? What are the pros and cons of these various options?**

See above.

4. **How can eligibility and enrollment be effectively coordinated between the Basic Health Program and other State programs to reduce churning between programs and promote continuity of care?**

A sizable proportion of Californians will likely churn between Medi-Cal and the BHP because of income changes. Similar "churn" is likely with the Exchange for different levels of subsidies or between the Exchange and the BHP. Operating the BHP through Medi-Cal, Healthy Families or the Exchange and building like infrastructure could help offset the issues raised by program churn, for example if the same provider networks are used across these programs. It may also provide administrative savings. To the extent permitted by federal law, an eligible individual enrolled in the BHP should continue to be eligible for BHP for a period of 12 months from the month eligibility is established.

The eligibility and enrollment vision in the ACA with simplification and electronic verification as primary objectives should make continuity of eligibility across the BHP, Exchange, Medi-Cal and Healthy Families seamless, despite income and other life circumstances changes.

5. **How could establishing a Basic Health Program affect the ability of an entire family to be covered by the same plan?**

The BHP could be operated under the current Healthy Families Program so that existing program contracts could be amended to enroll both child and parents to be enrolled in the same plan. As a condition of participation in the BHP, health plans could be required to participate in the Healthy Families Program.

However, BHP enrollees who would not be able to enroll in the Exchange may be limited in their choice of mainstream health plans and would not be eligible for tax credits. In addition, there may still be disruption in coverage as income fluctuates (the higher BHP income limit) and people move between BHP and the Exchange.

Fostering common family coverage where members have different sources of coverage is an important issue that Exchanges must consider regardless of BHP structure, since under any regime family members may end up having coverage from Medi-Cal, Healthy Families, their employer through the SHOP program or from individual coverage in the Exchange.

6. **Are standard health plans likely to also participate in other coverage programs, such as the Exchanges, Medicaid, or CHIP? Should this be encouraged, and if so, how could CMS and States encourage it?**

E. Amount of Payment

1. **The statute specifies that amounts in the trust fund may only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within a Basic Health Program. What options are States considering for reducing premiums and cost-sharing, or providing additional benefits? What, if any, guidance is needed on this provision?**

California's understanding of the current provisions is that a State that has a BHP is entitled to receive 95 percent of the value of the premium tax credit and cost-sharing reductions that the federal government would otherwise pay for Exchange coverage for each individual enrolled in the BHP. This is not an estimate, but a precise calculation that takes into account the age and income of the enrollee, whether the enrollment is for self only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. The funds are to be deposited in a trust and used only to pay premiums, reduce cost-sharing, or provide additional benefits to individuals in standard health plans. They may not be used as matching funds (ACA § 1331(d)).

Several Issues require further guidance:

- Can the federal payments be used for administration of the program?
- Would federal payments that are unexpended at the end of a fiscal year be permitted to be carried forward to the next fiscal year?
- Would federal BHP payments be reduced to states as part of the reconciliation process to the extent that there are overpayments?

2. **What are the likely administrative costs for a Basic Health Program? What factors, especially in terms of resources, are likely to affect a State's ability to establish a Basic Health Program? How are States likely to fund the costs associated with establishing and administering a Basic Health Program?**

3. **The statute specifies that in developing the financial methodology for the Basic Health Program, the determination of the value of the premium tax credits and cost-sharing reductions should take into consideration the experience of other States. What information would be most helpful to inform this methodology? Should implementation of the Basic Health Program be postponed until other States' experiences are available?**

4. **Other than those listed in the statute, what factors should be considered when establishing the methodology for determining the amount of Basic Health Program funding to States? How should the Federal government implement this calculation?**

To the extent BHP enrollees are served by FQHCs and that FQHC rates paid by BHPs are fixed by federal law, the payment rates to FQHCs should be considered in determining BHP funding to states.

5. **The statute specifies that the funding calculation is on a per-enrollee basis. How should the Federal government acquire the detailed information necessary to perform this calculation?**

6. **What are the best State-specific data sources to use in estimating the employer sponsored insurance?**

7. **What methods should be considered to measure and monitor compliance with the 95 percent cap on funding? How should CMS implement the provisions in Section 1331(d)(3)(B) of the Affordable Care Act regarding corrections to overpayments made in any year?**

F. Eligibility

1. **What education and outreach will be necessary to facilitate a helpful consumer experience?**

Education and outreach on eligibility criteria around the BHP, possibly in addition to education of the difference between criteria between the BHP, Medi-Cal and the Exchange, would enhance the consumer experience when evaluating their insurance options. There is likely to be significant consumer confusion if a Basic Health Program is enacted, particularly if it provides different benefits and covers different providers than Medi-Cal and the Exchange.

G. Secretarial Oversight

1. **What process should the Secretary use to certify or recertify Basic Health Programs? How should this process be similar to or different from Exchange certification?**

2. **What should be considered when developing an oversight process for the Basic Health Program?**